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Professional Services under Medical Care Insurance*

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MEDICAL care insurance is generally assumed to have a twofold purpose: (1) to reduce the financial burdens of illness by spreading the cost through the medium of prepayment, and (2) as a direct result of reducing the cost per individual, to increase the utilization of medical services. In addition, there should be two other important aims: (3) to improve the scope and quality of medical care for the insured population, and (4) to promote the prevention of disease and facilitate its detection at an early stage when it can be cured or arrested. In this age of preventive medicine, these last two purposes have become increasingly important. In evaluating the public significance of medical insurance programs, it is necessary today to reëxamine them in the light of all four criteria and to determine how far they meet these essential public health objectives.

THE BRITISH PLAN

The British health scheme has spread the cost of medical care largely by general taxation, and has admittedly increased the utilization of medical services by the insured population. The accuracy of reports of unnecessary overutilization of medical services is still debated. Some of the unusually heavy demand at the beginning was undoubtedly due to previously unmet medical needs. The burdensome volume of work in the average British physician's office also has other explanations, the demands of paper work not connected with medical services *per se,* and in some areas the shortage of physicians due to their maldistribution.

Aside from certain other features of the British health plan which are beyond the scope of this paper, there appear to be two major deficiencies in professional services: improvement in the quality of medical care is limited by the isolation of the general physicians, and little attention can be given to preventive medicine by these overburdened practitioners. The relationship of the general physician to the consulting specialists and laboratories is most inadequate, according to American standards.

AMERICAN VOLUNTARY PLANS

If we find the British program want-

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ing in the light of two of our four major criteria, we should examine our own voluntary plans of commercial and non-profit medical care insurance equally critically. An American business or industry, or a union welfare fund, is at liberty to purchase any of the available medical care insurance plans for its workers which, in its wisdom or ignorance, it considers most advantageous. The decision is usually based on one of two reasons—that the premiums are lower than those of any other available plan or that the medical benefits are comparatively greater. The average purchaser has as yet exhibited little interest in the scope and quality of the medical services which the subscribers will receive under the insurance plan or in the ability of the plan to provide preventive medical services and early detection of disease. Coverage is often limited to employees, in spite of the fact that the medical needs of the spouse and the children are often greater.

The medical insurance policies sold by commercial companies provide cash payments to indemnify the insured for some of the expenses incurred during an illness. They partially meet the first objective of medical insurance in that they serve to reduce the financial burden of some illnesses. In a long experience with private practice, I find that commercial medical expense indemnity plans do not appreciably increase the utilization of medical services by insured persons, perhaps largely because of the partial coverage and the additional charges for professional services. This is also true of many of the Blue Shield medical expense indemnity plans, even of those which include limited coverage for home and office care.

Blue Shield plans contract with local physicians to accept remuneration according to a fee schedule in full payment for such services but, in most plans of this type, only if the subscriber is in a very low income category. Physicians are at liberty as a rule to make additional charges to other subscribers. There are waiting periods, exclusions, limitations, requirement of extra payment for the first medical services, as deterrents to overutilization—a variety of safeguards against possible abuse of the fee-for-service system, which vary among the different plans throughout the country.

Some measure of the relative adequacy of medical expense indemnity insurance with limited coverage can be obtained from the financial reports of commercial and non-profit companies. One of the largest Blue Shield plans reports that it paid $6,782,000 to physicians in the year 1949 for the medical care of its 1,548,000 subscribers. This seems like a huge sum but it represents an average expenditure per subscriber of $4.38 per year. If a correction is made for persons who enrolled in the plan during the year and were not entitled to medical benefits during the entire period, the annual expenditure per subscriber is about $4.85. In contrast, the Health Insurance Plan of Greater New York is paying its medical groups at the rate of about $6,000,000 a year for the medical care of 255,000 subscribers. This represents an average expenditure per subscriber of about $24 per year and, because of the organization of its medical personnel for group practice, this sum purchases comprehensive coverage. Obviously, an expenditure of less than $5 a year per subscriber by a commercial or a non-profit medical expense plan with limited coverage, and payment of the physicians on a fee-for-service basis, can meet only a fraction of the cost of the total medical care required by the insured population.

Both commercial and Blue Shield plans have as yet revealed little if any demonstrable influence upon the scope and quality of medical care rendered by the participating physicians. They serve to perpetuate what Dr. Lester Evans has called "Episodic Medicine."

Nor do they, as a rule, cover those preventive medical services which are the basis for early disease detection.

GROUP PRACTICE UNDER A PREPAYMENT PLAN

Because of the limitations of ordinary medical expense insurance, it was the expressed intention of the founders of the Health Insurance Plan of Greater New York to encourage group practice as the best method of safeguarding and improving the scope and quality of medical care under a comprehensive prepayment plan. In this respect, the Plan follows the major recommendations of the national Committee on the Costs of Medical Care and, more recently, of the Committee on Medicine and the Changing Order of the New York Academy of Medicine. In setting up this community enterprise, the previous experience of individual medical groups in various parts of the country under local insurance plans was studied and freely utilized.

Under the Health Insurance Plan of Greater New York, thirty medical groups consisting of almost 900 general physicians and specialists representing the twelve basic specialties of medicine and surgery are now providing comprehensive medical care to 255,000 subscribers.* The great majority (about 211,000 persons) are enrolled under 66,000 family contracts. The comprehensiveness of the program can be judged by the fact that the subscribers are now receiving a million and a quarter of professional services a year.

The only conditions not accepted as the responsibility of the HIP medical groups are drug addiction, acute alcoholism, dental care, and conditions such as mental disorders and tuberculosis which require prolonged care in an institution other than a general hospital. The care of military-service-connected disabilities and of conditions covered by the Workmen's Compensation Act is provided outside the plan.

Medical groups which serve enrollees under this insurance plan are required by a Medical Control Board of representative physicians to meet adequate standards of professional staff organization, physical equipment, and professional training. The participating physicians and specialists in the groups improve in efficiency through team work. Whether the medical groups are recruited from the staffs of teaching hospitals, as in two instances, or whether the participating physicians and specialists represent only an average cross-section of the medical profession practising in the community, as is true of the majority of the HIP medical groups, they are capable of doing better professional work collectively than when practising in isolation. The availability of adequate laboratory resources, of specialist consultations in all fields of medicine and surgery, and of visiting nurses for home care without extra charges is particularly advantageous to the general physicians in the medical groups, who, as family physicians, have rendered 57 per cent of all of the medical services. The specialists on the team also profit professionally from their intimate relation with one another and from the free availability of laboratory services. Monthly or semimonthly staff conferences, which are required by rules of the Medical Control Board, stimulate the intimate working relationship between general physicians, specialists, and laboratory personnel.

UTILIZATION OF PROFESSIONAL SERVICES

To secure full utilization of professional services by subscribers and their

* The majority of the subscribers are employees of the city or of related agencies such as the Board of Transportation and the Triborough Bridge Authority, but workers in more than 200 private business and industrial organizations, social agencies, the United Nations, tenants in a low-cost coöperative housing project, and members of a number of labor union welfare funds are also enrolled in the plan.

families, medical care insurance must provide comprehensive coverage for all types of illness, minor as well as major, without waiting periods, exclusions, or extra payments designed to deter the subscriber from overutilization. Such deterring charges are required by medical insurance plans which remunerate the physician by a fee for each service. Because the Health Insurance Plan of Greater New York provides comprehensive medical care through group practice and distributes premium income to its medical groups on a capitation basis, it was found to be unnecessary under this plan to levy additional charges on the subscriber as a curb on overutilization or to require payment for the first few visits.

From our experience with comprehensive medical care under the Health Insurance Plan of Greater New York during the last three and a half years, the free availability of medical services of all kinds under a system of group practice has not resulted in general overutilization by the insured population. Abuses occur in isolated instances, which can be checked. As a matter of fact, underutilization continues to be characteristic of most workers and their families, in spite of the fact that comprehensive medical care is available to them without additional deterring charges. They must actually be taught to utilize physicians' services more adequately through a continuing program of health education before their average utilization rate approaches our previously estimated requirement of seven services per year per enrollee.

Upon analyzing the 1,800,000 or more physicians' services rendered by HIP medical groups during the first three years, we find that the utilization rate among HIP enrollees has shown a relation to the educational and cultural level of the subscribers. School teachers have the highest rate of utilization, averaging about six services per person per year, whereas the rate among workers in occupations requiring a lower order of education may be as low as three or four services per year, in spite of the fact that because of past neglect they may be in greater need of medical care.

Although the thirty medical groups under contract with HIP are prepared to render all the medical services which their enrollees require, we find that most subscribers need active instruction by the health education staff of HIP and by the physicians of their medical group in order to get them to make adequate use of all the medical skills and laboratory services to which they are entitled.

Subscribers usually have a higher utilization rate for a short time after they join the plan because of the number of unmet preëxisting medical needs, but the rate tends to drop later to a characteristic level. There are also marked seasonal variations among all categories.

The rate of utilization of medical services by the subscribers enrolled in each of the medical groups has also varied widely, from an average maximum of six professional services per year in some groups down to an average minimum of four. This has been discovered to be due in part to the composition of the subscriber enrollment in the various medical groups and in part to variations in practices in the different groups. The division of research and statistics of HIP reports periodically throughout the year on utilization rates among medical groups so that the performance of each of the groups is always conspicuously evident. This has stimulated some medical groups with low utilization figures to better their rates by holding health education meetings for their enrollees, by speaking at union meetings, and by the bimonthly publication and distribution of a health education bulletin to all their enrollees, a practice which is now carried on by twenty-six of the thirty medical groups.

As a result, the utilization rate after the initial period of heavy use has been slowly but consistently rising among the subscribers toward whom the most active health education program has been directed.

The past experience of HIP has also failed to confirm the fear that the availability of comprehensive medical care without deterring extra charges would result in an excessive demand for home calls. Under the plan the only extra charge to an enrolled subscriber which is permitted is $2 for a night call between the hours of 10 p.m. and 7 a.m. Home calls, chiefly by general physicians, internists, and pediatricians, constituted 12 per cent of the 1,800,000 physicians' services of all kinds provided during the first three years of the plan's operation. Nine per cent of all such services were rendered to patients in hospitals and 79 per cent in the medical centers of the groups and in doctors' offices.

ROLE OF THE GENERAL PHYSICIAN

In a recent address before the College of Physicians of Philadelphia, I spoke of the declining status of the general practitioner in modern society and the need for constructive action to correct this trend. Commercial and Blue Shield medical indemnity plans have no influence upon this most important unsolved problem of modern medicine. They leave the present status of the general physician unchanged. In fact, the numerous medical expense indemnity plans which cover only in-hospital surgical or surgical and medical cases provide income largely for the specialist and tend to make the position of the general physician relatively worse.

Under a non-profit medical insurance plan such as HIP, which provides comprehensive medical care through group practice, the general physician is a partner in the group and his relative financial rewards approach those of the specialists. Daily association with the senior members of the group and access to its laboratories provide a continuing educational experience, especially when the general practitioner sees all of his office patients at the medical center of the group, as is the rule with two of the HIP medical groups. For this reason all other HIP groups with outpost general physicians who see patients at their private offices near the patients' homes are now being required by HIP standards to have office hours for all general physicians at least once a week at the group center. For young physicians who join a medical group, the professional and financial opportunities are especially advantageous, for, unlike their experience in solo practice, their time is occupied from the first day of their careers with fruitful and edifying professional work. They are at liberty to supplement their income from the group by private practice on non-HIP patients and by Veterans Administration and Workmen's Compensation cases.

Like specialists, the general physicians of the groups have regular opportunities for vacations. Most evenings, Sundays, and holidays can be undisturbed, for each physician can alternate with his associates. From time to time, the physicians can afford to take sabbatical periods for special training in some special fields of medicine so that they may become more valuable members of the group. The groups are in a position to provide group insurance, and a study is currently under way on the possibility of providing retirement benefits for their members.

For the general physician it all adds up to greater professional satisfaction as well as economic security. The general physician is the keystone of medical practice. I am convinced that only by his association with specialists as equal partners in group practice can the ancient dignity and professional importance of the general physician be restored and enhanced.

PREVENTIVE MEDICINE

Limited coverage prepayment plans do little or nothing to advance the field of preventive medicine. Preventive medical services are not included under commercial or most Blue Shield plans because these forms of medical care insurance merely pay all or part of the bills for the medical services required for illness. The same deficiency in preventive medicine would exist under national compulsory medical insurance if it were designed, as in New Zealand, to perpetuate the present pattern of unorganized and completely decentralized medical practice, in which neither an individual physician nor a medical group is continuously responsible for the health as well as medical care of families.

In modern medical practice, in part because of our aging population, preventive medicine has become a growing responsibility of the medical profession rather than of health departments, for it involves the earliest possible detection of disease and of its precursors. This is best achieved when the health and welfare of family units under a prepaid comprehensive medical care plan are the complete responsibility of a coördinated medical group. Only under these circumstances is it possible to direct an educational program at family units so as to teach them to use the available professional services more adequately for disease prevention.

The members of the HIP medical groups paid on a capitation basis are learning by experience that the costly burdens of preventable illnesses and accidents drain their professional and financial resources. For these and other reasons, it is becoming easier to persuade the groups to develop a comprehensive program of preventive medicine for their enrollees. Under the Health Insurance Plan of Greater New York, preventive medicine is emphasized as a major function of the medical groups; a special division has recently been established at central headquarters under the full-time direction of an outstanding leader in health education, for the purpose of assisting the groups to develop and maintain higher standards for their preventive services.

In one of the HIP medical groups a family counselling service has just been established on an experimental basis with the assistance of the Community Service Society. There has been much discussion in recent years concerning preventive psychiatry but no agreement on how or where to apply such services effectively. A family counselling facility as part of a prepaid comprehensive health service of a medical group may prove to be a logical point of attack upon this overwhelming problem of present-day society.

QUALITY OF MEDICAL CARE

A detailed study of the comparative quality of medical care rendered by twenty-six of the medical groups in HIP was recently completed by Dr. Henry Makover. I shall refer here only to the fact that the survey employed a special technic for measuring the quality of medical care rendered by medical groups so that the professional performances actually achieved by the best groups could be used as yardsticks for comparing the relative performance of other groups serving under a common medical insurance program. Attention was concentrated chiefly upon the standards of service in preventive medicine, pediatrics, cancer detection, and gastrointestinal disorders, because these seemed to be good indices for judging the professional performances of the various groups. Such a study of the impact of medical care insurance upon the scope and quality of professional services has not yet been made for commercial or Blue Shield plans.

Another example of the opportunities which exist to measure professional performance in a special field of medicine

is revealed by a recent study of maternity services under the Health Insurance Plan of Greater New York, which I reported upon last May before the International Congress on Obstetrics and Gynecology in collaboration with Dr. Neva R. Deardorff. Surgical intervention (Cesarean section) was required in only 2.7 per cent of the obstetrical deliveries, compared with 4.7 per cent for the City of New York generally. That there was no neglect is indicated by the fact that there were no maternal deaths in 1,015 consecutive deliveries during the period under study (July 1, 1948, to June 30, 1949). The neonatal mortality was 9 per 1,000 live births, compared with 20 per 1,000 for the city as a whole during the corresponding 12 month period. This favorable experience occurred in spite of an adverse selection due to the enrollment of older childbearing females in the Health Insurance Plan than is the average in the city at large. The relative proportion of HIP primipara and multipara 35 to 39 years of age was twice that reported for the City of New York; the proportion of multipara over 40 was double and of primipara over 40 four times that for the city.

In a similar manner, the experience of the plan in a variety of other clinical fields is being used as a yardstick for measuring the general adequacy of its medical services and for determining their costs. Such studies can only be conducted under a plan in which comprehensive medical care is provided for the subscribers and their families through organized medical group practice without any extra charges to deter the enrollees from fully utilizing the available preventive and curative services of family physicians, consulting specialists, diagnostic laboratories, and visiting nurses. Moreover, such studies require a central organization with a medical as distinguished from a purely insurance outlook.

VISITING NURSE SERVICES

Visiting nurse services in the homes and ambulance transportation to a hospital are included under the plan without extra cost. The nurses are provided by the Visiting Nurse Services of New York and of Brooklyn and by similar agencies in Staten Island and the suburbs. The two large city agencies, like the medical groups, receive per capita remuneration based upon the number of enrolled subscribers in their territory. The capitation rates are readjusted every six months, the readjustment being based upon utilization data for the preceding period. There is still much work to be done in teaching physicians as well as enrolled subscribers to use the services of visiting nurses more effectively. It is also our intention to integrate the visiting nurses more directly into the health education program.

SUMMARY

A medical care insurance plan should be capable of meeting four criteria of adequacy. It should:

1. Reduce the financial burdens of illness as much as possible by spreading the cost through prepayment;
2. Increase the utilization of medical services by the insured population;
3. Improve the scope and quality of medical care;
4. Promote disease prevention and early detection.

These four criteria can be met by a non-profit medical care insurance program only if it provides comprehensive coverage without disease exclusions or additional deterring charges and if it serves family units through complete medical groups of general physicians and specialists.

The Health Insurance Plan of Greater New York is demonstrating that these four objectives can be accomplished within the limitations of a reasonable premium income when the medical serv-

ices are rendered by group practice and premium income is distributed to the medical groups on a capitation basis. After three and a half years, thirty autonomous medical groups totalling almost 900 general physicians and specialists are providing comprehensive medical care under the Health Insurance Plan of Greater New York to more than 255,000 enrolled persons, including preventive services and visiting nurse services in the homes, without waiting periods or disease exclusions and without deterring extra charges.

Dr. Gorgas Named to Hall of Fame

William Crawford Gorgas, M.D., was among only six nominees who received the necessary majority in the 1950 election held in November for a place in the Hall of Fame for Great Americans at New York University. By destroying breeding places of yellow fever mosquitoes in the Panama Canal Zone he made possible the building of the Canal. Elections for the Hall of Fame are held every five years and only seven names may be added in any one year from candidates who have been dead at least 25 years. In 1950 the six names were selected from 186 nominated by private citizens throughout the country.

Dr. Gorgas, an officer of the Army Medical Corps, attained the rank of surgeon general. The Gorgas Memorial Institute of Tropical and Preventive Medicine, Washington, D. C., and the Gorgas Memorial Laboratory of Tropical Research in Panama have also been established in his honor.